COMPLAINT FORM

Please print or type

1. Name of complainant: _____

2. Address and telephone number of complainant:

Address:_____

City:_____

State:_____

Zip:_____

Daytime phone number: _____ Evening phone number:_____

3. Relationship of complainant to patient:

☐ self ☐ physician ☐ friend ☐ son/daughter
☐ spouse ☐ parent ☐ brother/sister ☐ legal guardian
☐ other - please specify _____

4. Name of patient (if different) and patient's date of birth:

_____Date of b irth:_____

5. Full name of practitioner about whom you are complaining (provide a separate complaint form for each physician, midwife, podiatrist, physician assistant, occupational therapist/assistant, respiratory therapist, athletic trainer, acupuncturist or clinical exercise physiologist against whom you wish to complain):

_____

Please check:

☐ MD ☐ Acupuncturist ☐ Occupational Therapist Assistant ☐ Midwife
☐ DO ☐ Athletic Trainer ☐ Clinical Exercise Physiologist ☐ Unknown
☐ Podiatrist ☐ Occupational Therapist ☐ Respiratory Therapist ☐ Unlicensed
☐ Physician Assistant

Address and telephone number of practitioner or allied health professional:

Address:_____

City:_____

State:_____

Zip:_____Phone:_____

Approximate Dates of Treatment: From_____ to _____

6. Nature of Complaint (check all that apply):

- ☐ Poor medical care
- ☐ Rude or discourteous behavior
- ☐ Over utilization of testing
- ☐ Suspected impairment (drugs or other condition)
- ☐ Sexual misconduct
- ☐ Failure to release patient records
- ☐ Substance abuse
- ☐ Insurance fraud
- ☐ Poor communication skills or poor "bedside manner"
- ☐ Problem other than listed above _____

_____

7. Please **attach** a clear and concise description of the nature of your complaint.

8. _____
Complainant's Signature Date

9. AUTHORIZATION TO RELEASE YOUR COMPLAINT INFORMATION TO THE DOCTOR.
Complete form for **complaint release authorization**.

10. How did you know about the Board of Medical Examiners? (e.g., news media, from family or friends, your physician, etc.):

_____

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